AMENDED IN SENATE JUNE 25, 2015

AMENDED IN ASSEMBLY MAY 5, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1305

Introduced by Assembly Member Bonta

February 27, 2015

An act to amend ~~Section~~ *Sections* 1367.006 *and 1367.007* of the Health and Safety Code, and to amend ~~Section~~ *Sections* 10112.28 *and 10112.29* of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1305, as amended, Bonta. Limitations on cost sharing: family coverage.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA establishes annual limits on specified forms of cost sharing, including deductibles, on all essential health benefits for nongrandfathered individual and group health insurance coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires, for nongrandfathered products in the individual or small group markets, a health care service plan contract or health insurance policy, except a specialized health care service plan or health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, to provide

for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, and requires the plan contract or policy, for nongrandfathered products in the large group market, to provide that limit for covered benefits to the extent that the limit does not conflict with federal law or guidance, as specified. Existing law prohibits this limit from exceeding the limit described in a specified provision of federal law.

This bill would require, for family coverage, the above-described limit on annual out-of-pocket expenses to include a maximum out-of-pocket limit for each individual covered by the plan contract or policy that is less than or equal to the maximum out-of-pocket limit for individual coverage under the plan contract or policy. The bill would require a plan contract or policy *and, commencing July 1, 2016, a large group market plan contract or policy,* for family coverage that includes a deductible, except a high deductible health plan, to include a deductible for each individual covered under the plan contract or policy that is less than or equal to the deductible for individual coverage under the plan contract or policy. The bill would require a plan contract or policy *and, commencing July 1, 2016, a large group market health plan contract or policy,* for family coverage that includes a deductible and is a high deductible health plan, as defined in federal law, to include a deductible for each individual covered by the plan contract or policy that is equal to either the amount set forth in a specified *provision of* federal law or the deductible for individual coverage under the plan contract or policy, whichever is greater. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.006 of the Health and Safety Code is amended to read:

1367.006. (a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health care service plan contracts in the individual or small group markets, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4.

(2) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care consistent with Section 1371.4. This limit shall only apply to essential health benefits, as defined in Section 1367.005, that are covered under the plan to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health care service plan contracts in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, the limit described in subdivision (b) shall include a maximum out-of-pocket limit for each individual covered by the plan that is less than or equal to the maximum out-of-pocket limit for individual coverage under the plan contract.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section

1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g) (1) *(A)* Except as provided in paragraph (2), if a health care service plan contract for family coverage includes a deductible, the plan contract shall include a deductible for each individual covered by the plan that is less than or equal to the deductible for individual coverage under the plan contract.

(B) Except as provided in paragraph (2), if a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after July 1, 2016, includes a deductible, the plan contract shall include a deductible for each individual covered by the plan that is less than or equal to the deductible for individual coverage under the plan contract.

(2) *(A)* If a health care service plan contract for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(B) If a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after July 1, 2016, includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(h) For nongrandfathered health plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, "plan year" means the calendar year.

(i) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 2. Section 1367.007 of the Health and Safety Code is amended to read:

1367.007. (a) (1) For a small employer health care service plan contract offered, sold, or renewed on or after January 1, 2014, the deductible under the plan shall not exceed:

(A) Two thousand dollars ($2,000) in the case of a plan contract covering a single individual.

(B) Four thousand dollars ($4,000) in the case of any other plan contract.

(2) The dollar amounts in this section shall be indexed consistent with Section ~~1302(c)(2)~~ *1302(c)(1)* of PPACA and any federal rules or guidance pursuant to that section.

(3) The limitation in this subdivision shall be applied in a manner that does not affect the actuarial value of any small employer health care service plan contract.

(4) For small group products at the bronze level of coverage, as defined in Section 1367.008, the department may permit plans to offer a higher deductible in order to meet the actuarial value requirement of the bronze level. In making this determination, the department shall consider affordability of cost sharing for enrollees and shall also consider whether enrollees may be deterred from seeking appropriate care because of higher cost sharing.

(b) Nothing in this section shall be construed to allow a plan contract to have a deductible that applies to preventive services as defined in Section 1367.002.

(c) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

~~SEC. 2.~~

SEC. 3. Section 10112.28 of the Insurance Code is amended to read:

10112.28. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27, including out-of-network emergency care.

(2) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health insurance policies in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, the limit described in subdivision (b) shall include a maximum out-of-pocket limit for each individual covered by the policy that is less than or equal to the maximum out-of-pocket limit for individual coverage under the policy.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section

1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.

(g) (1) *(A)* Except as provided in paragraph (2), if a health insurance policy for family coverage includes a deductible, the policy shall include a deductible for each individual covered under the policy that is less than or equal to the deductible for individual coverage under the policy.

(B) Except as provided in paragraph (2), if a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after July 1, 2016, includes a deductible, the policy shall include a deductible for each individual covered under the policy that is less than or equal to the deductible for individual coverage under the policy.

(2) *(A)* If a health insurance policy for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.

(B) If a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after July 1, 2016, includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.

(h) For nongrandfathered health insurance policies in the group market, "policy year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, "policy year" means the calendar year.

(i) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 4. Section 10112.29 of the Insurance Code is amended to read:

10112.29. (a) (1) For a small employer health insurance policy offered, sold, or renewed on or after January 1, 2014, the deductible under the policy shall not exceed:

(A) Two thousand dollars ($2,000) in the case of a policy covering a single individual.

(B) Four thousand dollars ($4,000) in the case of any other policy.

(2) The dollar amounts in this section shall be indexed consistent with Section ~~1302(c)(2)~~ *1302(c)(1)* of PPACA and any federal rules or guidance pursuant to that section.

(3) The limitation in this subdivision shall be applied in a manner that does not affect the actuarial value of any small employer health insurance policy.

(4) For small group products at the bronze level of coverage, as defined in Section 10112.295, the department may permit insurers to offer a higher deductible in order to meet the actuarial value requirement of the bronze level. In making this determination, the department shall consider affordability of cost sharing for insureds and shall also consider whether insureds may be deterred from seeking appropriate care because of higher cost sharing.

(b) Nothing in this section shall be construed to allow a policy to have a deductible that applies to preventive services as defined in PPACA.

(c) This section shall not apply to multiple employer welfare arrangements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 that provide health care benefits to their members and that comply with small

group health reforms unless otherwise required by federal law or guidance.

(d) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

~~SEC. 3.~~

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O